Q1. Page 18 (Section 3.1.1.x) of the RFP states that TFC vendors must "provide individual counseling, as needed, to meet the child's treatment goals. Individual counseling must be provided by a qualified professional that meets the definition as described in Chapter 105 of the Medicaid Manual."

a. Is it expected that TFC vendors begin contracting with a therapist to provide individual counseling, and/or must vendors hire an in-house therapist?
b. How will these services be paid for?
c. May providers coordinate services with a local mental health clinic or individual that accepts Medicaid and utilize the child's Medicaid coverage to pay for services?

R1. If the child needs counseling, the TFC provider may provide the counseling as a core service and bill Medicaid on EDS to help get their daily rate.

Q2. Page 18 (Section 3.1.1.y) of the RFP states that TFC vendors must "provide medication administration and monitoring." Please clarify the definitions of "administration" and "monitoring." Do these services need to be provided by a psychiatrist? Must vendors contract with a psychiatrist to provide these services? How will these services be paid for?

R2. These are Medicaid Rehab services and are described in Chapter 105 of the Medicaid manual.

Q3. Page 18 (Section 3.1.3.b) of the RFP states the TFC vendor must "provide forty hours (40) of pre-service training, including GPS, to TFC families prior to licensure." Deciding Together is not included in this sentence. Is it to be assumed that Deciding Together is considered part of GPS, or was Deciding Together removed from the pre-service training requirement?

R3. Deciding Together may be used in the place of GPS, when and only when a foster parent is not able to meet for the 10 week GPS classes.

Q4. What qualifications are needed to be able to provide GPS to families?

R4. GPS trainers must be certified.

Q5. Page 24 (Section 4.2.5.1.2) of the RFP states "the vendor must not include references from Department state office staff in the following divisions: procurement, personnel, resource management, and family services." May vendors use County DHR staff as references? Can out-of-state references be used? If a vendor has both DHR county references and references from payers in other states, is there a preference for which type should be used?

R5. The requirement for REFERENCES has been eliminated from this RFP. The points previously assigned to REFERENCES, have been reallocated to VENDOR PROFILE AND EXPERIENCE.

Q6. Page 26 (Section 4.2.5.3.1) of the RFP states "All requirements in *Section 3: Scope of Project* must be addressed in the Service Delivery Approach. Is it preferred that Vendors follow the outline and section and subsection names/numbers in Section 3 in

order, or can vendors organize the information in a different way, as long as all requirements are addressed? Can services for TFC & step-down TFC be addressed in the same section, or must the same services for step-down be repeated in a separate step-down section?

R6. To meet the requirement in Section 4.2.5.3.1 Vendors should follow and use the subsection titles as outlined in Section 3 as a guide. TFC and Step-down should be addressed in separate sections.

Q7. Was it an omission in this description that children served in this level no longer have to have an Axis I diagnosis? (Historically this was required AND problems also had to be present)

a. How will children be deemed appropriate for referrals?

R7. Children served in a TFC foster home must have a Diagnostic & Statistical Manual, Fourth Edition (DSM-IV) Axis I diagnosed mental illness or be identified by a mental health professional as having at least moderate emotional and/or behavioral problems and be in need of treatment and structure offered through a TFC placement.

Q8. Is a psychological evaluation no longer required for admission?

R8. Refer to the TFC Manual.

Q9. Was the use of the MAT not to be included in our referral process and admission criteria?

R10. Refer to the TFC Manual.

Q11. Is a diagnosis by a mental health professional acceptable for admission as stated without a current psychological evaluation?

R11. No.

Q12. RFP Page 7, section 1.0 What is meant by the statement "while receiving intensive treatment and clinical services'?

a. Do these services differ from services provided in the past by TFC providers?
b. "Must be continually evaluated to determine the need for these services".... How will the need be continually evaluated and how will it need to be documented?

R12. The services are the same as those currently being provided by TFC providers. The MAT will be utilized by the Department. TFC providers may use their choice of assessment tools, many use GAF scores.

Q13. RFP Page 18, section 3.1.2 A – D Are these responsibilities to be shared with other contract providers, such as Continuum of Care providers, when both agencies are involved? Who will have primary responsibility?

R13. This RFP is separate from continuum services. TFC agencies are responsible for providing services to birth families.

Q14. RFP Page 18 section 3.1.3 b. Services to TFC Families May this be changed to read "provide 40 hours of pre-service training, including GPS ***or Deciding Together,*** to TFC families prior to licensure"?

R14. Deciding Together is within the GPS training criteria. See pervious answer to this question.

Q15. RFP Page 21, section 3.2.1 x. Is it the expectation that TFC providers will have counselors on staff to provide this service?

a. May providers use community resources, such as local mental health centers to obtain these services?
b. Why has this been added as a core service when there has been no increase in the daily rate?

R15. This was added last year to assist TFC providers in billing to reach their daily rate. If the TFC agency provides the service, they must have staff on board to bill as Medicaid Rehab services.

Q16. RFP Page 23, section 4.2 Can the blind review process be further explained in regards to where the Vendor Identifier will be used?

a. Why is this necessary at this time?
b. Will there be value placed on past experience and commitment and how does this "blind review" impact that value?

R16. Vendors must submit six copies of their proposal using the Vendor identifier in place of the agency name. The Department has determined it to be in its best interest to utilize Vendor identifiers. Use of a Vendor identifier will not impact the scoring process.

Q17. Section 1.7.1, pg. 9 Can the letter of intent be submitted via e-mail attachment?

R17. No.

Q18. Section 3.1.1 (h), pg. 17. Is there a minimum number of hours of individual and/or group basic living skills training that the vendor must provide?

R18. Refer to Section 3.1.1 of the RFP.

Q19. Section 3.2.1 (q), pg. 20. Over the last year DHR has tracked outcomes for TFC providers. Will preference be given to current providers who have demonstrated successful outcomes?

R19. No.

Q20. Section 4.2, pg. 23. Please explain exactly what a bidder is to use for the "vendor identifier." Will it be issued by DHR?

R20. The Department will assign an identifier to all vendors that attend the pre-proposal conference.

Q21. Section 6.0, pg. 29. Will a point value be associated with a provider's history of successful outcomes in the proposal evaluation?

R21. No.

Q22. Section 3.1.1, Item X, Page 17. Could DHR please clarify if provider agencies are required to provide individual counseling or if this service can be referred to community mental health agencies? This question also applies to Section 3.2.1, Item X, Page 21.

R22. See R15.

Q23. Section 4.2.5.2, Page 25. How does DHR recommend that providers submit audited financial statements that do not identify the provider agency?

R23. Original proposals and one copy will identify agencies. Agencies may use whatever means are necessary to delete identifying information from six copies of the financial statements.

Q24. Section 5.0. Could DHR elaborate on the exact criteria by which the Service Rate section of the proposals will be evaluated if the rate section consists of a fixed rate of $95.00 per day?

R24. The "exact criteria" is not available. In addition, although a fixed rate of $95 per day has been specified, Vendors may propose a rate lower.

Q26. Appendix F, Item IX, Page 40. Does DHR want providers to include potential Medicaid income as Program Income? If so, will there be some sort of a net Medicaid system of payment as is currently utilized by DHR?

R26. No.

Q27. This question is in reference to **Section 3.1.2 page 18, item c**. Can the 2 hour therapeutic visitation between the client and family with the case manager also count for the case manager's face to face visit with the client for that week?

R27. Yes, if the case manager actually provides the supervision and spends one-on-one time with the child. If the TFC foster parent provides the supervision, it can not count.

Q28. This question is in reference to **Section 3.1.2 page 18, item c**. What are the procedures/requirements for documenting the case manager's provision of therapeutic visitation between the client and family each week and how is this information communicated to DHR?

R28. The parents/age appropriate child must sign a sign in sheet that the service was provided. It shall be maintained in the child's folder at the TFC agency office. It is communicated to the DHR case worker in the monthly report as well as by telephone contact.

Q29. This question is in reference to **Section 3.1.1 page 18, item x**. Will children that already have an identified therapist outside of the TFC agency be required to change to the TFC provider's therapist due to individual counseling now being listed as a core service?

R29. No.

Q30. This question is in reference to **Section 3.1.1 page 18, item x.** Can the TFC client's case manager also be the designated therapist for the child?

R30. No.

Q31. This question is in reference to **Section 3.1.1 page 18, item x.** What are the skill level expectations of TFC staff to provide individual counseling services to TFC clients, other than the credential requirements per Chapter 105 of the Medicaid manual?

R31. They must currently meet the requirements set forth by Medicaid.

Q32. This question is in reference to **Section 3.1.1 page 18, item y.** What services are required for medication administration and monitoring for Standard TFC and does it only apply to Standard TFC, not step-down TFC? Do the terms "medication administration" mean TFC parent training to administer the client's medications or does this core service require the provider to employ or contract with a psychiatrist for medication administration and monitoring?

R32. These are Medicaid billable services and are described in the Medicaid 105 Manual.

Q33. Medication monitoring and administration is listed as a core service in the RFP for both standard TFC but not for step-down. Why?

R33. It should be in both, if needed and identified in the ISP.

Q34. In the current TFC contract, individual counseling is not required of the provider, but is optional. It is our understanding that this will be a required core service for both standard and step-down in the upcoming contracts. Is our understanding correct?

R34. It is optional. Listing it as a core service allows the TFC agency to bill Medicaid directly for the service, if provided.

Q35. Section 4.2.5.3.4, Page 26. Will the department allow for capacity building in terms of readiness for the projected number of TFC homes proposed in the RFP?

R35. The homes must be ready for usage by October 01, 2008.

Q36. Section 4.2.5.1.1, Page 24. Is it acceptable for a provider with prior similar history to respond including both prior experience and the proposed plans for provision of TFC services in this RFP?

R36. Yes.

Q37. Section 4.2.5.1.1, page 24. Is it acceptable and expected that the organization's board of directors' identity be included in this RFP?

R37. Yes, the Board of Directors may be included in the original proposal. However, the names of board members should be excluded from the copies, leaving only the position titles.

Q38. Section 4.2.5.3.1, page. 26 Given the level and intensive needs of youth who are most at risk for out-of-home care, will the department allow for recognized advanced skill training that's designed to help change behavior, promote safety, improve well being and permanency as long as the required 40 hours are met?

R38. After standard mandatory requirements are met, TFC providers may utilize supplemental training curricula.

Q39. Section 4.2.5.1.5, page 25 Will the resume of a Consultant be allowed in this RFP?

R39. See R37.

Note: Vendors must receive a minimum score of 850 points to be considered for a contract.